



NORTHWESTERN  
HEALTH SCIENCES  
UNIVERSITY

Thank you for choosing The Bloomington Natural Care Center at Northwestern Health Sciences University for your health care needs. We are confident that you will be satisfied with the services that we offer.

Please fill out the enclosed health questionnaire and the 6 day diet diary prior to your initial appointment. Bring with you all supplements and medications that you currently take. If you have had blood work or other lab tests done in the past year, please try to have copies of the results available to look over as well.

If you need to cancel or reschedule your appointment, kindly give 24 hours notice.

We look forward to meeting you and introducing you to natural health care options.

Sincerely,

Stephani Waldron-Trapp, N.D.

## Naturopathic Medical History Form

Patient name: \_\_\_\_\_ Age: \_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_  
 Parent or guardian name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_ Zip code: \_\_\_\_\_  
 Phone numbers: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ phone: \_\_\_\_\_  
 Who referred you to us? \_\_\_\_\_

**Please note that preventive medicine and holistic health care are only possible when the physician has a complete picture of the patient physically, mentally and emotionally. We are asking you to provide us with part of this picture by carefully and thoroughly completing this form. Thank you for your time and patience.**

### PRIMARY HEALTH CONCERNS:

**In your opinion, what are your most important health concerns (chief complaints)?**

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Others: \_\_\_\_\_

### PRIOR TREATMENTS AND RESPONSE:

**Please list all of the former treatments** you have used, both conventional and alternative and the degree of effectiveness of each treatment. This greatly aids us in developing an optimal treatment plan for you.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### MEDICAL HISTORY

**What childhood illnesses have you had?**

- |   |  |                                       |                                     |
|---|--|---------------------------------------|-------------------------------------|
| <input type="radio"/> Rubella (german/3day measles) | <input type="radio"/> Measles (2 week) | <input type="radio"/> Mumps           | <input type="radio"/> Chickenpox    |
| <input type="radio"/> Whooping cough                | <input type="radio"/> Polio            | <input type="radio"/> Rheumatic fever | <input type="radio"/> Scarlet fever |
| <input type="radio"/> Roseola                       | <input type="radio"/> Asthma           | <input type="radio"/> Others _____    |                                     |

**Please mark if you have any of the following now, in the past, or never.**

	NOW	PAST	NEVER		NOW	PAST	NEVER
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypoglycemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Candida/yeast	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Drug use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart murmur	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Alcohol use	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injury (serious)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver dz./jaundice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypothyroid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overweight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperthyroid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (specify) _____				Venereal dz.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				- specify _____			

**HOSPITALIZATIONS (list as best you can):**

Type of illness or operation/procedure:	Date	Hospital

Type of Xray or diagnostic procedure:	Date	Hospital/Clinic

**FAMILY HISTORY – Please list medical conditions. If deceased, list what age and cause of death.**

<u>Mother's side</u>	<u>Father's side</u>
Mother _____	Father _____
Grandfather _____	Grandfather _____
Grandmother _____	Grandmother _____
Your sisters _____	Your brothers _____

**Has any BLOOD RELATIVE had any of the following:**

	YES	NO	UNSURE		YES	NO	UNSURE
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High blood pr.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Seizure/epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sickle cell anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thyroid (hyper/hypo)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Venereal dz.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (specify) _____				- specify _____			

**MEDICATIONS/SUPPLEMENTS - List what you are currently taking and the dosage per day.**

Drugs	Vitamins/Minerals	Homeopathics	Herbs

**ALLERGIC REACTIONS**

Are you allergic to any medicines or other substances? If yes, please list: \_\_\_\_\_

What happens when you have an allergy attack? \_\_\_\_\_

What prior types of allergy testing have you had?

- Intradermal  
  Scratch  
  Blood IgG food  
  Blood IgE inhalant/food  
  Cytotoxic  
 Electroacupuncture (VEGA, MORA)  
  Kinesiology  
  Food intolerance testing  
  None

Reveiled allergins: \_\_\_\_\_

Which of the following are bothersome to you or are known allergies?

- |  |  |   |                                   |
|--|--|---|-----------------------------------|
| <input type="radio"/> Sunshine             | <input type="radio"/> Dust                 | <input type="radio"/> Dampness                          | <input type="radio"/> Lack of sun |
| <input type="radio"/> Dryness              | <input type="radio"/> New moon             | <input type="radio"/> Tobacco smoke                     | <input type="radio"/> Cold        |
| <input type="radio"/> Perfume              | <input type="radio"/> Heat                 | <input type="radio"/> Spring                            | <input type="radio"/> Summer      |
| <input type="radio"/> Winter               | <input type="radio"/> Fall                 | <input type="radio"/> Dogs                              | <input type="radio"/> Cats        |
| <input type="radio"/> Seashore             | <input type="radio"/> Grasses/weeds        | <input type="radio"/> Mountains                         | <input type="radio"/> Car fumes   |
| <input type="radio"/> Mold                 | <input type="radio"/> Full moon            | <input type="radio"/> Chemicals (specify) _____         |                                   |
| <input type="radio"/> Fluorescent lighting | <input type="radio"/> Approach of storms   | <input type="radio"/> Change of weather (specify) _____ |                                   |
| <input type="radio"/> Tree pollens         | <input type="radio"/> Poor air ventilation | <input type="radio"/> Other _____                       |                                   |

**HOME ENVIRONMENT – Which of the following do you routinely use at home?**

- Forced air     Radiant heat     Gas heat     Oil heat     Electric heat
- Wood stove     Air conditioning     Electric blanket     T.V.     Microwave
- Feather pillow     Heated waterbed     Computer screen     Other \_\_\_\_\_

**OTHER ENVIRONMENTAL EXPOSURES**

- Are your home and work environments well ventilated? Yes    No
- Are your home or work environments excessively Moist    Dry
- Are there unusual or unpleasant smells in your work/living environment? Yes    No
- When were the ducts in your home last cleaned? \_\_\_\_\_
- Do you get outdoors daily, even in winter? Yes    No

**SOCIAL HISTORY**

- Are you currently: Single    Have one partner    Married    Divorced    Separated
- Prefer relations with: Male    Female    Male and female
- Have you traveled outside of the United States in the past year? No    Yes: Where? \_\_\_\_\_
- Do you have a support system? No    Yes: Who? \_\_\_\_\_
- How do you feel about your work? \_\_\_\_\_

How would you describe your relationships with co-workers? \_\_\_\_\_

**HEALTH HABITS**

- How often do you drink: wine \_\_\_\_\_ beer \_\_\_\_\_ other alcohol \_\_\_\_\_
- Do you use tobacco or have you in the past? No    Yes    Years since quitting: \_\_\_\_\_
- Have you lived with someone who smokes inside? No    Yes: How long?\_\_
- Do you now or have you in the past used marijuana or other drugs? No    Yes
- If yes, which drugs, how often and how long? \_\_\_\_\_
- Have you ever been exposed to toxic chemicals, solvents or other possible toxins?  Yes  No
- If yes, please explain: \_\_\_\_\_
- Do you exercise? No    Yes: What form(s)? \_\_\_\_\_
- How often? \_\_\_\_\_ How long for? \_\_\_\_\_
- Do you make time for relaxation or meditation? No    Yes: How often? \_\_\_\_\_
- What are your interests and hobbies? \_\_\_\_\_
- Which of the following do you do on a regular basis: Jog    Swim    Walk    Bicycle    Yoga
- Gardening    Breathing exercises    Meditation    Weightlifting    Other:\_\_\_\_\_

**DIET**

- How many meals do you generally eat each day? One \_\_ Two \_\_ Three \_\_ More than three \_\_
- Where do you usually buy your food? \_\_\_\_\_
- Who cooks the food you eat? \_\_\_\_\_
- List the primary foods included in your diet for:
- Breakfast \_\_\_\_\_
- Snack \_\_\_\_\_
- Lunch \_\_\_\_\_
- Snack \_\_\_\_\_
- Dinner \_\_\_\_\_
- Snack \_\_\_\_\_
- List the foods you exclude from your diet and why: \_\_\_\_\_

List any foods you crave, regardless of their nutritional value (includes sweets, chocolate, salty, sour, bread, rich/fatty foods, etc.): \_\_\_\_\_

List any foods to which you have a bad reaction and how you react: \_\_\_\_\_

- Are you thirsty?  No     Yes    Amount of plain water you drink each day \_\_\_\_\_
- What type of water do you drink? Distilled water    Filtered    Spring    Well    Deionized    Tap
- What temperature liquid to you prefer to drink?  Hot     Cold     Room temp

**SLEEP & ENERGY**

What time do you go to bed? \_\_\_\_\_ Wake up? \_\_\_\_\_ If you wake at night, what time(s)? \_\_\_\_\_  
Do you have trouble falling asleep? No Yes If yes, what keeps you up? \_\_\_\_\_  
Do you have recurring dreams? No Yes If yes, what is the theme? \_\_\_\_\_  
Do you wake feeling refreshed? No Yes  
What position do you sleep in? \_\_\_\_\_  
Is there a position you cannot sleep in? No Yes If yes, which one and why? \_\_\_\_\_  
What is your energy level 1-10 with 10 being the most energy? \_\_\_morning \_\_\_afternoon \_\_\_evening

**SYMPTOMS – Please mark if you experience the following symptoms now or have in the past.**

**Integument (Skin and Hair)**

NOW PAST

\_\_\_\_\_ Skin rough, dry, scaly, bumpy, itchy (circle if applicable).  
\_\_\_\_\_ Rashes, warts, moles, cysts (circle). Have any changed in size/color lately? \_\_\_\_\_  
\_\_\_\_\_ Light or dark patches of skin (circle if applicable).  
\_\_\_\_\_ Pimples. List location(s): \_\_\_\_\_  
\_\_\_\_\_ Color changes, ridges, pits, white spots on nails (circle if applicable).  
\_\_\_\_\_ Loss of hair. List location(s). \_\_\_\_\_  
\_\_\_\_\_ Hives. List what causes them: \_\_\_\_\_  
\_\_\_\_\_ Scars. List location(s): \_\_\_\_\_

**Hematopoietic, Lymph, Immune**

NOW PAST

\_\_\_\_\_ Painful lymph nodes  
\_\_\_\_\_ Difficulty stopping bleeding  
\_\_\_\_\_ Bleeding from unusual places  
\_\_\_\_\_ Bruising easily  
\_\_\_\_\_ Wounds heal slowly  
\_\_\_\_\_ Anemia  
\_\_\_\_\_ Swollen glands  
\_\_\_\_\_ Fluid retention  
\_\_\_\_\_ Date of last BLOOD TESTS

**Endocrine**

NOW PAST

\_\_\_\_\_ Unexplained weight loss/gain  
\_\_\_\_\_ Prefers hot weather  
\_\_\_\_\_ Prefers cold weather  
\_\_\_\_\_ Can't stand cold  
\_\_\_\_\_ Can't stand heat  
\_\_\_\_\_ Cold hands and feet  
\_\_\_\_\_ Fatigue, long term  
\_\_\_\_\_ Weakness  
\_\_\_\_\_ Increased thirst  
\_\_\_\_\_ Increased hunger

**Head**

NOW PAST

\_\_\_\_\_ Dizziness  
\_\_\_\_\_ Severe headaches  
\_\_\_\_\_ Seizures, convulsions  
\_\_\_\_\_ Fainting spells  
\_\_\_\_\_ Head trauma

**Ears**

NOW PAST

\_\_\_\_\_ Discharge from ears  
\_\_\_\_\_ Hearing problems  
\_\_\_\_\_ Sensitivity to noise  
\_\_\_\_\_ Pain in ears  
\_\_\_\_\_ Ringing in ears  
\_\_\_\_\_ Date of last hearing check

**Eyes**

NOW PAST

\_\_\_\_\_ Poor eyesight (near or far)  
\_\_\_\_\_ Floaters  
\_\_\_\_\_ Discharge  
\_\_\_\_\_ Light hurts eyes  
\_\_\_\_\_ Double vision  
\_\_\_\_\_ If older than 50, date of last glaucoma check

**Nose**

NOW PAST

\_\_\_\_\_ Nasal scabs/crusts  
\_\_\_\_\_ Sinus congestion  
\_\_\_\_\_ Loss of smell  
\_\_\_\_\_ Nose bleeds

**Mouth**

NOW PAST

\_\_\_\_\_ Sore mouth or tongue  
\_\_\_\_\_ Speech difficulties  
\_\_\_\_\_ Bleeding gums

**Throat**

NOW PAST

\_\_\_\_\_ Recurrent strep throat  
\_\_\_\_\_ Difficulty swallowing

NOW PAST

- \_\_\_ \_\_\_ Loss of teeth
- \_\_\_ \_\_\_ Cold sores, blisters
- \_\_\_ \_\_\_ Amount of mercury amalgam

NOW PAST

- \_\_\_ \_\_\_ Persistent hoarseness
- \_\_\_ \_\_\_ Loss of voice
- \_\_\_ \_\_\_ Chronic sore throat or pain

**Respiratory**

NOW PAST

- \_\_\_ \_\_\_ Unexplained fever
- \_\_\_ \_\_\_ Chest pain when breathing
- \_\_\_ \_\_\_ Wheezing
- \_\_\_ \_\_\_ Difficulty breathing at night
- \_\_\_ \_\_\_ Chest congestion

NOW PAST

- \_\_\_ \_\_\_ Dry sweats
- \_\_\_ \_\_\_ Night sweats
- \_\_\_ \_\_\_ Shortness of breath
- \_\_\_ \_\_\_ Daily cough

Have you ever been exposed to T.B. (tuberculosis)?  Yes  No

When was your last T.B. test? \_\_\_\_\_ Results? \_\_\_\_\_

When was your last chest X-ray? \_\_\_\_\_ Reason? \_\_\_\_\_ Results? \_\_\_\_\_

Have you ever blown into a chamber as a test for lung function/capacity?  No  Yes: Date \_\_\_\_\_

How many pillows do you sleep on? \_\_\_\_\_

**Cardiovascular**

NOW PAST

- \_\_\_ \_\_\_ Chest pain when walking
- \_\_\_ \_\_\_ Chest pain when sitting/lying
- \_\_\_ \_\_\_ Ankle or abdominal swelling
- \_\_\_ \_\_\_ Heart palpitations – fibrillation  
flutter, skipping beat, beating  
fast, beating slow (circle if yes)
- \_\_\_\_\_ Date of any blood vessel studies

NOW PAST

- \_\_\_ \_\_\_ Leg vein problems
- \_\_\_ \_\_\_ Leg pain when walking
- \_\_\_ \_\_\_ Numbness/tingling in arms/legs
- \_\_\_ \_\_\_ Heart murmur (type) \_\_\_\_\_
- \_\_\_\_\_ Date of last exercise stress test
- \_\_\_\_\_ Date of last EKG
- \_\_\_\_\_ Date of last echocardiogram

Have you had rheumatic fever or syphilis?  No  Yes: when \_\_\_\_\_

How far can you walk? \_\_\_\_\_

How many stairs can you climb before having to stop? \_\_\_\_\_ Why do you stop? \_\_\_\_\_

**Urinary**

NOW PAST

- \_\_\_ \_\_\_ Frequent urination
- \_\_\_ \_\_\_ Night urination
- \_\_\_ \_\_\_ Difficulty holding urine
- \_\_\_\_\_ Dates of cystoscopy, IVP, KUB, X-rays.

NOW PAST

- \_\_\_ \_\_\_ Painful urination.
- \_\_\_ \_\_\_ Difficulty starting urine
- \_\_\_ \_\_\_ Blood in urine

**Gastrointestinal**

NOW PAST

- \_\_\_ \_\_\_ Constipation
- \_\_\_ \_\_\_ Diarrhea
- \_\_\_ \_\_\_ Alternating constipation/diarrhea
- \_\_\_ \_\_\_ Change in bowel movements
- \_\_\_ \_\_\_ Strain at stool
- \_\_\_ \_\_\_ Hemorrhoids
- \_\_\_ \_\_\_ Black stools or blood in stools
- \_\_\_ \_\_\_ Light colored or greasy stools
- \_\_\_ \_\_\_ Stool color: \_\_\_\_\_
- \_\_\_ \_\_\_ Formed/loose/hard pellets
- \_\_\_ \_\_\_ Undigested matter
- \_\_\_ \_\_\_ Number of bowel movements a day
- \_\_\_ \_\_\_ Vomiting blood
- \_\_\_ \_\_\_ Date of last HEMOCCULT  
test (hidden blood in stool)

NOW PAST

- \_\_\_ \_\_\_ Indigestion immediately after eating a meal
- \_\_\_ \_\_\_ Indigestion 2-3 hours after meals (discomfort)
- \_\_\_ \_\_\_ Stomach pain 5-6 h after eating, usually at  
night, relieved by eating or drinking
- \_\_\_ \_\_\_ Above symptoms worse with worry/stress
- \_\_\_ \_\_\_ Heavy, full after eating
- \_\_\_ \_\_\_ Nervous, shaky, headache, better sweets
- \_\_\_ \_\_\_ Sudden cravings for sweets or alcohol
- \_\_\_ \_\_\_ Irritable if late for a meal, miss meal or on  
waking
- \_\_\_ \_\_\_ Appetite change - increase or decrease
- \_\_\_ \_\_\_ Loss of appetite
- \_\_\_ \_\_\_ Insatiable appetite
- \_\_\_ \_\_\_ Weight change - increase or decrease
- \_\_\_ \_\_\_ Diet but fail to lose weight
- \_\_\_ \_\_\_ Eat but fail to gain weight

NOW PAST

- \_\_\_ \_\_\_ Frequent or severe nausea
- \_\_\_ \_\_\_ Heartburn
- \_\_\_ \_\_\_ Trouble swallowing
- \_\_\_ \_\_\_ Excessive belching
- \_\_\_ \_\_\_ Excessive lower bowel gas
- \_\_\_ \_\_\_ Difficulty belching, stomach cramps, colic
- \_\_\_ \_\_\_ Abdominal bloat/distension
- \_\_\_ \_\_\_ Distress from fat/greasy food
- \_\_\_ \_\_\_ Bad breath
- \_\_\_ \_\_\_ Body odor (incl. feet)

NOW PAST

- \_\_\_ \_\_\_ Overweight
- \_\_\_ \_\_\_ Underweight
- \_\_\_ \_\_\_ Compulsive eating
- \_\_\_ \_\_\_ Addictive eating
- \_\_\_ \_\_\_ Anorexia
- \_\_\_ \_\_\_ Bulimia
- \_\_\_ \_\_\_ Stomach/abdominal pain
- \_\_\_ \_\_\_ Yellow jaundice
- \_\_\_ \_\_\_ Bad taste in mouth
- \_\_\_ \_\_\_ Intestinal parasites suspected
- \_\_\_ \_\_\_ Date of last sigmoidoscopy

**Male Reproductive**

NOW PAST

- \_\_\_ \_\_\_ Prostate problems
- \_\_\_ \_\_\_ Swelling, lumps, pain in testicles
- \_\_\_ \_\_\_ Discharge from penis
- \_\_\_ \_\_\_ Infertility

NOW PAST

- \_\_\_ \_\_\_ Painful erection
- \_\_\_ \_\_\_ Difficulty achiev/maint. erection
- \_\_\_ \_\_\_ Difficulty /premature ejaculation
- \_\_\_ \_\_\_ Date of last prostate exam

Are you currently sexually active?  No  Yes If yes, number of partners: \_\_\_\_\_  
 What type of contraceptive do you use? \_\_\_\_\_

**Female Reproductive**

NOW PAST

- \_\_\_ \_\_\_ Lumps in breast(s)
- \_\_\_ \_\_\_ Nipple discharge
- \_\_\_ \_\_\_ Breast pain
- \_\_\_ \_\_\_ Pelvic pain
- \_\_\_ \_\_\_ Discharge from vagina
- \_\_\_ \_\_\_ Vaginal itching/burning
- \_\_\_ \_\_\_ Genital eruptions (specify)

NOW PAST

- \_\_\_ \_\_\_ Painful sex
- \_\_\_ \_\_\_ Lack of sexual desire
- \_\_\_ \_\_\_ Difficulty feeling sexual arousal
- \_\_\_ \_\_\_ Never/seldom have orgasms
- \_\_\_ \_\_\_ Menstruation excessive
- \_\_\_ \_\_\_ Menstruation absent
- \_\_\_ \_\_\_ Bleed/spot between periods

Age of first menstruation \_\_\_\_\_  
 Periods occur every \_\_\_ days. Ever miss period?  Yes  No Periods usually last \_\_\_ days on average.  
 Size of tampon/pad \_\_\_\_\_ Change every \_\_\_ hours/day Color of blood \_\_\_\_\_ Clots?  Yes  No  
 Date of last period \_\_\_\_\_. Date of last PAP smear \_\_\_\_\_ Normal?  Yes  No: \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_ Was it normal?  Yes  No: \_\_\_\_\_

Have you ever used birth control pills?  No  Yes: How long? \_\_\_\_\_ Side effects? \_\_\_\_\_  
 Have you ever used an IUD?  No  Yes: How long? \_\_\_\_\_ Side effects? \_\_\_\_\_  
 Are you currently sexually active?  No  Yes: Number of partners: \_\_\_\_\_  
 Method of contraception: \_\_\_\_\_

Have you had in the past, or do you currently have difficulties getting pregnant? \_\_\_\_\_  
 \_\_\_ # of pregnancies \_\_\_ # of births \_\_\_ # of miscarriages \_\_\_ # of abortions  
 Any complications of pregnancy?  No  Yes If yes, please explain: \_\_\_\_\_

Please mark if these symptoms occur: B if before, D if during or A if after menstruation.

PMT-A

- \_\_\_ Nervous tension
- \_\_\_ Irritability
- \_\_\_ Mood changes
- \_\_\_ Anxiety
- \_\_\_ Insomnia
- \_\_\_ Fatigue

PMT-D

- \_\_\_ Depression
- \_\_\_ Forgetful
- \_\_\_ Crying
- \_\_\_ Confusion
- \_\_\_ Dizziness or faint

PMT-C

- \_\_\_ Headache
- \_\_\_ Craving for sweets
- \_\_\_ Increased appetite
- \_\_\_ Heart pounding

PMT-H

- \_\_\_ Weight gain
- \_\_\_ Abdominal bloating
- \_\_\_ Swelling extremities
- \_\_\_ Breast tenderness

**Pituitary**

NOW PAST

- \_\_\_ \_\_\_ Poor memory
- \_\_\_ \_\_\_ Increased sexual desire
- \_\_\_ \_\_\_ Splitting headaches
- \_\_\_ \_\_\_ High/low sugar tolerance
- \_\_\_ \_\_\_ Abnormal thirst
- \_\_\_ \_\_\_ Ulcers, colitis

NOW PAST

- \_\_\_ \_\_\_ Low blood pressure
- \_\_\_ \_\_\_ Decreased sexual desire
- \_\_\_ \_\_\_ Menstrual disorders
- \_\_\_ \_\_\_ Intestinal bloating
- \_\_\_ \_\_\_ Chunky hips or waist

**Thyroid**

NOW PAST

- \_\_\_ \_\_\_ Overweight
- \_\_\_ \_\_\_ Difficulty losing weight
- \_\_\_ \_\_\_ Constipation
- \_\_\_ \_\_\_ Tired upon rising
- \_\_\_ \_\_\_ Easily fatigued
- \_\_\_ \_\_\_ Dry or scaly skin
- \_\_\_ \_\_\_ Chilly/sensitive to cold
- \_\_\_ \_\_\_ Mental slowness
- \_\_\_ \_\_\_ Date of last thyroid test

NOW PAST

- \_\_\_ \_\_\_ Decreased appetite
- \_\_\_ \_\_\_ Nervousness
- \_\_\_ \_\_\_ Heart palpitations
- \_\_\_ \_\_\_ Irritable/restless
- \_\_\_ \_\_\_ Increased appetite
- \_\_\_ \_\_\_ Underweight
- \_\_\_ \_\_\_ Flush/get hot easily
- \_\_\_ \_\_\_ Insomnia

**Adrenals**

NOW PAST

- \_\_\_ \_\_\_ Easily stressed
- \_\_\_ \_\_\_ Easily/chronically fatigued
- \_\_\_ \_\_\_ Dizziness
- \_\_\_ \_\_\_ Headaches
- \_\_\_ \_\_\_ Hot flashes
- \_\_\_ \_\_\_ Bronzing of the skin
- \_\_\_ \_\_\_ Craves salt

NOW PAST

- \_\_\_ \_\_\_ Nails weak, ridged
- \_\_\_ \_\_\_ Tendency to get hives
- \_\_\_ \_\_\_ Rheumatism/arthritis
- \_\_\_ \_\_\_ Poor circulation
- \_\_\_ \_\_\_ Increased blood pressure
- \_\_\_ \_\_\_ Weak after getting a cold
- \_\_\_ \_\_\_ Facial hair (women)

**Sympathetic Nervous System**

NOW PAST

- \_\_\_ \_\_\_ Upset from acid foods
- \_\_\_ \_\_\_ Dry eyes, nose, mouth
- \_\_\_ \_\_\_ Nervousness
- \_\_\_ \_\_\_ Wounds that heal slowly
- \_\_\_ \_\_\_ Gag easily
- \_\_\_ \_\_\_ Very quick mentally

NOW PAST

- \_\_\_ \_\_\_ Cold extremities
- \_\_\_ \_\_\_ Light sensitive
- \_\_\_ \_\_\_ Decreased urine output
- \_\_\_ \_\_\_ Heart pounds when lying down
- \_\_\_ \_\_\_ Reduced appetite
- \_\_\_ \_\_\_ Frequent cold sweats

**Parasympathetic Nervous System**

NOW PAST

- \_\_\_ \_\_\_ Joint stiffness on rising
- \_\_\_ \_\_\_ Muscle/leg/toe cramps
- \_\_\_ \_\_\_ Butterflies in stomach
- \_\_\_ \_\_\_ Digestion rapid
- \_\_\_ \_\_\_ Indigestion after eating
- \_\_\_ \_\_\_ Perspiration scant/absent
- \_\_\_ \_\_\_ Perspire easily/profusely

NOW PAST

- \_\_\_ \_\_\_ Frequent vomiting
- \_\_\_ \_\_\_ Alternating constipation/diarrhea
- \_\_\_ \_\_\_ Pulse slow/regular
- \_\_\_ \_\_\_ Breathing irregular
- \_\_\_ \_\_\_ Poor circulation
- \_\_\_ \_\_\_ Eyelids swollen/puffy

**Central and Peripheral Nervous System**

NOW PAST

- \_\_\_ \_\_\_ Loss of balance/fainting
- \_\_\_ \_\_\_ Dizziness regularly
- \_\_\_ \_\_\_ Convulsions (seizures)
- \_\_\_ \_\_\_ Tremor (shaking, trembling)
- \_\_\_ \_\_\_ Blurred/double vision

NOW PAST

- \_\_\_ \_\_\_ Paralysis
- \_\_\_ \_\_\_ Numbness/tingling (circle)
- \_\_\_ \_\_\_ Temporary loss of sensation
- \_\_\_ \_\_\_ Lack of strength
- \_\_\_ \_\_\_ Continual headache

**Musculo-Skeletal**

NOW PAST

- \_\_\_\_ \_\_\_\_ One arm or leg shorter
- \_\_\_\_ \_\_\_\_ Joint pain/stiffness/ swelling
- \_\_\_\_ \_\_\_\_ Loss of strength
- \_\_\_\_ \_\_\_\_ Painful feet, ankles or calves
- \_\_\_\_ \_\_\_\_ Arthritis
- \_\_\_\_ \_\_\_\_ Type: \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ Location: \_\_\_\_\_

NOW PAST

- \_\_\_\_ \_\_\_\_ Muscle pain or stiffness
- \_\_\_\_ \_\_\_\_ Where? \_\_\_\_\_
- \_\_\_\_ \_\_\_\_ Coughing, sneezing or straining at stools
- \_\_\_\_ \_\_\_\_ Intensifies back pain
- \_\_\_\_ \_\_\_\_ Hernia
- \_\_\_\_ \_\_\_\_ Muscle wasting
- \_\_\_\_ \_\_\_\_ Other: \_\_\_\_\_

Date of last spinal X-rays: \_\_\_\_\_ Findings? \_\_\_\_\_

Date of last bone density test: \_\_\_\_\_ Findings? \_\_\_\_\_

Have you been diagnosed with osteopenia or osteoporosis?  No  Yes: Location \_\_\_\_\_

**OTHER INFORMATION**

Please tell me if there is anything else you would like me to know or if you have a concern about something that you would like to be addressed?

I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I understand and agree that, regardless of my insurance status, I am responsible for the balance on this account for any services, medications or laboratory work.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**THANK YOU FOR TAKING THE TIME TO FILL OUT THIS HISTORY QUESTIONNAIRE.**

**Name:** \_\_\_\_\_ **Dates:** \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Please indicate all foods, liquid, or other items ingested throughout the day along with the amounts of each.  
Please include seasonings, condiments, supplements, gum, mints, etc... (basically everything).

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack time:
<b>Liquids</b> consumed and amount of each:					
<b>Energy level</b> and time of day(energetic, tired, heavy, other):					
<b>Other:</b> supplements, medicine, gum or other miscellaneous items consumed:					
<b>Bowel movements: #/day</b> _____ <b>Color</b> _____ <b>Smell:</b> foul, no smell <b>Any bloating or gas</b> throughout the day? yes / no <b>Circle if any apply:</b> hard, loose, watery, difficult, easy, blood, mucous, undigested food, pain/discomfort –location _____					

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## COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

**Stephani Waldron-Trapp, N.D.**  
**Northwestern Health Sciences University, Bloomington Natural Care Center**  
**(This Statement is required by Section 146 A.11 of the Minnesota Statutes.)**

1. **Name and address of Unlicensed Complementary and Alternative Health Care Practitioner (the "Practitioner")**. Stephani Waldron-Trapp, N.D.; Bloomington Natural Care Center, 2501 W. 84<sup>th</sup> Street, Bloomington, MN 55431; (952) 885-5444.
2. **Qualification of Practitioner**. Doctor of Naturopathic Medicine, University of Bridgeport College of Naturopathic Medicine (Bridgeport, Connecticut) (2005), Passed Naturopathic Physicians Licensing Examinations (Bridgeport, Connecticut) (2005), License as Naturopathic Physician (Vermont) (2005), B. Sc. in Biology, St. Cloud State University (St. Cloud, Minnesota) (2000), Nationally Certified in Therapeutic Massage and Bodywork (Minneapolis, Minnesota) (1998), Massage Therapist, Center Point (Minneapolis, Minnesota) (1996).  
**THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.**  

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.
3. **Supervisor of practitioner**. Deborah Miller; Northwestern Health Sciences University, 2501 W. 84<sup>th</sup> Street, Bloomington, Minnesota 55431; (952) 888-4777.
- 4.
5. **Complaints**. As a complementary and alternative health care client ("Client"), you have the right to file a complaint with the supervisor listed in paragraph 3 above. Any such complaint should be directed to the attention of the supervisor, in writing, and should include supporting details sufficient to permit an investigation into the complaint to be commenced.
6. **Office of Complementary and Alternative Health Care Practice**. Office of Complementary and Alternative Health Care Practice, Health Occupations Program, 400 Metro Square Building, P.O. Box 64975, St. Paul, MN 55164-0975, (651) 282-6344. As a Client, you may file complaints with such offices.
7. **Fees**. The Practitioner's fees are billed and due upon completion of services rendered, and are as follows: For new patients: \$225 for 110 minutes of consultation; \$170 for 80 minutes of consultation; \$120 for 50 minutes of consultation; and \$90 for 40 minutes of consultation. For follow-up visits with existing patients: \$130 for 80 minutes of consultation; \$105 for 50 minutes of consultation; \$90 for 40 minutes of consultation; and \$70 for 25 minutes of consultation and \$45 for 10 minutes of consultation. No insurance companies have agreed to reimburse the Practitioner. The Practitioner does not contract with any health maintenance organization to provide service. The Practitioner does not accept Medicare, medical assistance or general assistance medical care. The Practitioner is not willing to accept partial payment, or to waive payment.
8. **Notice of Changes in Services or Charges**. As a Client, you have the right to reasonable notice of changes in services or charges.
9. **Theoretical Approach**. In general, the Practitioner's choice of modalities depends on your needs as a client. The Practitioner typically uses one or more of the following combinations: ayurveda; cranial sacral therapy; culturally traditional healing practices; detoxification practices and therapies; energetic healing; folk practices; healing practices utilizing food, food supplements, nutrients, and the physical forces of heat, cold, water, touch, and light; herbology or herbalism; homeopathy; non-diagnostic iridology; body work, massage and massage therapy; meditation; mind-body healing practices; naturopathy; noninvasive instrumentalities; and traditional Oriental practices, such as Qi Gong energy healing.
10. **Right to Information**. As a Client, you have the right to complete and current information concerning the Practitioner's assessment and recommended service that is to be provided, including the expected duration of the services to be provided.
11. **Treatment**. As a Client, you may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the Practitioner.
12. **Client Records/Transactions**. Client records and transactions with the Practitioner are confidential, unless release of these records is authorized in writing by you as the Client, or otherwise provided by law.
13. **Access to Records**. As a Client, you have the right to be allowed access to records and written information from records in accordance with Section 144.335 of the Minnesota Statutes.
14. **Other Services**. Other services may be available in the community. Information concerning such services may be found in the Natural Care Center brochure.
15. **Right to choose**. As a Client, you have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.
16. **Coordinated Transfer**. As a Client, you have the right to coordinated transfer when there will be a change in the provider of services.
17. **Refusal of Service**. As a Client, you have the right to refuse service or treatment, unless otherwise provided by law.
18. **Assertion of Rights**. You have the right to assert your rights without retaliation.

### **Acknowledgement by Client**

I hereby Attest that I have received a copy of The Complementary and Alternative Health Care Bill of Rights in relation to services to be provided to me by Stephani Waldron-Trapp, N.D., as required by Section 146A.11 of the Minnesota Statutes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



NORTHWESTERN  
HEALTH SCIENCES  
UNIVERSITY

## Cancellation Policy

At least a 24-hour notice of cancellation made during business hours is required if you need to cancel your scheduled appointment. If cancellation is made less than 24 hours before the appointment, you will be billed for the missed appointment.

You have contracted with your practitioner for an allotted amount of time. The 24-hour notice allows waiting list clients to fill this time. Please be aware that these charges are not covered by any insurance and are the direct responsibility of the client/patient.

This policy was instituted for the benefit of both clients and practitioners. We appreciate your cooperation in this manner. We look forward to serving you in the future.

I have read and understand the above information.

---

Signature of Client/Patient

---

Date

### Northwestern Health Sciences University Natural Care Center Locations

Bloomington Natural Care Center  
2501 W. 84<sup>th</sup> Street  
Bloomington, MN 55431  
Ph: 952-885-5444

The Natural Care Center at Woodwinds  
1875 Woodwinds Dr., Suite 100  
Woodbury, MN 55125  
Ph: 651-232-6830

**Northwestern Health Sciences University Clinic System**  
**CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**OUR PRIVACY PLEDGE:** The NWHSU-Clinic System is concerned with and committed to the protection of our patients' and clients' privacy and ensuring the confidentiality of personal health information entrusted to us.

Ways in which the University may use or disclose your health care information include, but are not limited to:

- Another health care provider within the University Clinic System, or to another provider or facility for the purpose of diagnosis, assessment or treatment of your health condition.
- Another party, such as an insurance carrier, HMO or employer for the purpose of receiving payment for services rendered to you.
- The use of that information within our practice for quality control or other operational purposes.
- Business associates that we contract with to perform a service for your benefit.
- Research, when the University review board has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- The use of that information to contact you by telephone, mail or e-mail with appointment reminders, lab or imaging results, information about our clinic facilities, treatment alternatives or other health-related information that may be of interest to you.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. The current notice, including the effective date, will be posted in the clinic facility, on the University web site at [www.nwhealth.edu](http://www.nwhealth.edu), and will be given to you when you come in for treatment.

**Your Right to Limit Uses or Disclosures:** You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions; however, if we agree with your restrictions, the restriction is binding on us.

**Your Right to Revoke Your Authorization:** You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

**YOU HAVE A RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUT YOUR CONSENT, HOWEVER, THE NWHSU-CLINIC SYSTEM WILL NOT BE ABLE TO SUBMIT CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.**

Initial here

[       ] I acknowledge receipt of the NWHSU-Notice of Privacy Practices

By signing below, I give consent to the NWHSU-clinicians or staff to disclose my personal health information as noted above.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date